

**TouchChi Intake Form \*\*\*CONFIDENTIAL\*\*\***

The following information is requested to better understand your desire for your session and tailor the experience to your individual needs. Complete and save this form, then email it to info@touchchi.net.

Name:

Telephone:

Address:

City:

State:

Zip:

Email:

I heard about you from:

Do you have preferred days or times for scheduling with us? (e.g., Tues morning, Weds 6pm, Saturdays)

Are you currently taking any medications? If yes, please describe the medication and condition.

For the following, please note any conditions you currently have or have had in the past.

Blood clot	Heart conditions	Hemorrhaging	Stroke
Hypertension/High- blood pressure	Varicose Vein	Loss of muscle tissue	Strains/sprains
Arthritis	Broken/dislocated bones	Laminectomy of vertebrae	Whiplash
Back conditions	Bruise easily	Cancer/tumors	Chronic pain
Diabetes	Fatigue	Headaches	Pregnancy
Skin Conditions	Surgery		

Details on above conditions, or other conditions not listed above:

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Do you have any of the following today? If yes, please provide more detail in the space provided.

Cold/flu/contagious ailment

Injuries/bruises

Open cuts

Severe pain

Skin rash

Swelling/inflammation

Do you have allergies or reactions to the following? If yes, please provide more detail in the space provided.

Environmental allergens (e.g., fragrances,  
incense, dust, pollen)

Skin care products

Is there any other information we should know before proceeding with the massage?

What is your Intention for your session today?

As massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

Signature:

Date: